ITEM 9. CLINIC SERVICES (Continued)

1. Psychotherapy:

A method of treatment of mental disorders using the interaction between a therapist and a patient to promote emotional or psychological change to alleviate mental disorder. Psychotherapy also includes family therapy when only one family is being treated. Psychotherapy may be provided in any setting except skilled nursing or intermediate care facilities or the facilities of the Vermont State Hospital or the Brandon Training School.

2. Group Therapy:

A method of treatment of mental disorders, using the interaction between a therapist and two or more patients to promote emotional or psychological change to alleviate mental disorders. Group therapy may, in addition, focus on the patient's adaptational skills involving social interaction and emotional reactions to reality situations. Group therapy may be provided in any setting except skilled nursing or intermediate care facilities or the facilities of the Vermont State Hospital or the Brandon Training School.

3. Day Hospital:

Day Hospital is an intensive service provided in clinic facilities that provides active treatment which can reasonably be expected to lead to full or partial recovery of the patient (client). Day Hospital services are provided as an alternative to inpatient care for clients with mental illness of an acute and/or episodic nature. A variety of treatment modalities is available, including individual, group and family therapy, chemotherapy and treatment-related activity programs.

4. Chemotherapy (Med-Check)

Prescription of psychoactive drugs to favorably influence or prevent mental illness by a physician, physician's assistant, or nurse performing within the scope of their license. Chemotherapy also includes the monitoring and assessment of patient reaction to prescribed drugs. Chemotherapy may be provided in any setting except skilled nursing or intermediate care facilities, or the facilities of the Vermont State Hospital or the Brandon Training School.

ITEM 9. CLINIC SERVICES (Continued)

5. Diagnosis and Evaluation

A service related to identifying the extent of a patient's (client's) condition. It may take the form of a psychiatric and/or psychological and/or developmental and/or social assessment, including the administration and interpretation of psychometric tests. It may include: an evaluation of the client's attitudes, behavior, emotional state, personality characteristics, motivation, intellectual functioning, memory and orientation; an evaluation of the client's social situation relating to family background, family interaction and current living situation; an evaluation of the client's social performance, community living skills, self-care skills and prevocational skills; and/or an evaluation of strategies, goals and objectives included in the development of a treatment plan, program plan of care consistent with the assessment findings as a whole.

6. Emergency Care

A method of care provided for persons experiencing an acute mental health crisis is evidenced by (1) a sudden change in behavior with negative consequences for wellbeing; (2) a loss of usual coping mechanisms, or (3) presenting a danger to self or others. Emergency care includes diagnostic and psychotherapeutic services such as evaluation of the client and the circumstances leading to the crisis, crisis counseling, screening for hospitalization, referral and follow-up. Emergency services are intensive, time-limited and are intended to resolve or stabilize the immediate crisis through direct treatment, support services to significant others, or arrangement of other more appropriate resources.

ITEM 10. DENTAL SERVICES

Effective January 1, 1989, dental services are provided to beneficiaries of all ages.

Limitations for services for beneficiaries age 21 or older are:

SERVICES NOT COVERED FOR BENEFICIARIES OVER 21*:

- Bonding and sealants
- Single crowns
- Peridontal care and periodontal surgery
- Dentures (full or partial) and other prosthetic care except denture adjustments
- Crown and bridge
- Orthodontia
- Elective and cosmetic care

LIMITED SERVICES FOR BENEFICIARIES OVER 21:

- Endodontia, not to exceed three teeth treated per beneficiary
- All third molar surgery for beneficiaries over 21 years requires prior authorization
- Crown build up (code 02950) is limited to endodontially treated teeth

In addition, the adult dental benefit maximum of $475.00 per beneficiary per calendar year is imposed.

Coverage of Dentures is detailed in Attachment 3.1-A, page 5c, Item 12.

* With the exception of services authorized for coverage via the procedure for requesting Medicaid coverage of a service or item (M108) found at Attachment 3.1-A Page 6o.

ITEM 11. PHYSICAL THERAPY AND RELATED SERVICES

a,b,c, Physical therapy, occupational therapy and services for individuals with speech, hearing, and language disorders are limited as follows:

1) to those provided in the outpatient department of a hospital, nursing facility*, or Medicare certified rehabilitation agency; and by staff therapists of a home health agency or comprehensive outpatient rehabilitation facility;

2) to four month duration from start of outpatient therapy unless prior authorization is granted for an extended time period;

3) no coverage beyond one year unless the service may not be reasonably provided by the patient's support person(s) and the patient undergoes another acute care episode or injury. experiences increased loss of function, or deterioration of the patient's condition requiring therapy is imminent and predictable.

4) Services provided by independently practicing therapists are not covered.

5) Analog hearing aids are covered for beneficiaries, when medically necessary. Digital hearing aids are covered with prior authorization for beneficiaries under age 21 when they are determined to be medically necessary pursuant to §1905 (r) of the Social Security Act. Unless authorized via the procedure for requesting Medicaid coverage of a service or item (M108) found at Attachment 3.1-A Page 6o, digital hearing aids are not available for beneficiaries age 21 and older.

*PT, OT, and ST for an inpatient of the facility are covered in the nursing facility per diem.

ALTERNATE FOR DRUGS

ITEM 12.a. PRESCRIBED DRUGS*

1. Drugs listed by the FDA as less than effective are not covered by Medicaid, nor are the generic equivalents of the listed drugs covered.*

2. Physicians and Pharmacists are required to conform to Act 127 (18 VSA Chapter 91), otherwise known as the Vermont Generic Drug Law. In those cases where the Generic Drug Law permits substitution, only the lowest priced equivalent in stock at the pharmacy shall be considered medically necessary. Medicaid will not pay if the recipient refuses the substitution required by law.*

3. A pharmacist must fill prescriptions in quantities of between 30 and 60 days supply all drugs prescribed for continued regular use. The physician may prescribe for particular patients or conditions in lesser amounts and in these instances the pharmacist is required to fill as directed.

4. Multivitamins are covered only for pregnant or lactating women; and for other particular conditions by prior authorization.*

5. Coverage for certain other drugs is limited to specific conditions, e.g. amphetamines for the treatment of narcolepsy cataplexy syndrome only.*

6. Over-the-counter drugs are covered only when prescribed in large quantities for continuing use in treatment of specific conditions and with prior authorization.*

7. Contraceptive drugs, supplies and birth control devices are covered and claimed at the increased Federal match under Family Planning.

8. No coverage is provided for items such as:*

Dentifrices and dental adhesives
Baby oils
Soaps and shampoos - nonmedicated, (medicated products may be covered when prescribed by a physician)
Food products and food supplements; (payment may be made for food supplements (e.g., Sustacal) in cases where a person's nutritional needs can only be met by a liquid high protein diet.)
Baby formula; e.g., Enfamil, ProSobee, Similac (with or without iron), etc.
Sugar substitutes; e.g., Saccharin, Sweets, etc. Antiseptics; e.g., Merthiolate, Tincture of Iodine, etc.

*With the exception of prescriptions authorized for coverage via the procedure for requesting Medicaid coverage of a service or item (M108) found at Attachment 3.1-A Page 6o. This procedure may be applied to all prescribed drugs.

Original

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.
[X] Provided: [ ] No limitations [ ] With limitations*
[ ] Not provided.

b. Dentures.
[X] Provided. [ ] No limitations [X] With limitations*
[ ] Not provided.

c. Prosthetic devices.
[X] Provided [ ] No limitations [X] With limitations*
[ ] Not provided.

d. Eyeglasses.
[X] Provided. [ ] No limitations [X] With limitations*
[ ] Not provided.

13. Other diagnostic, screening, preventive, and rehabilitation services, i.e., other than provided elsewhere in the plan.
[X] Provided. [ ] No limitations [X] With limitations*
[ ] Not provided.

*Description provided on attachment.

ALTERNATE FOR DRUGS

ITEM 12.a. PRESCRIBED DRUGS

1. Drugs listed by the FDA as less than effective are not covered by Medicaid, nor are the generic equivalents of the listed drugs covered.

2. Physicians and Pharmacists are required to conform to Act 127 (18 VSA Chapter 91), otherwise known as the Vermont Generic Drug Law. In those cases where the Generic Drug Law permits substitution, only the lowest priced equivalent in stock at the pharmacy shall be considered medically necessary. Medicaid will not pay if the recipient refuses the substitution required by law.

3. A pharmacist must fill prescriptions in quantities of between 30 and 60 days supply all drugs prescribed for continued regular use. The physician may prescribe for particular patients or conditions in lesser amounts and in these instances the pharmacist is required to fill as directed.

4. Multivitamins are covered only for pregnant or lactating women; and for other particular conditions by prior authorization.

5. Coverage for certain other drugs is limited to specific conditions, e.g. amphetamines for the treatment of narcolepsy cataplexy syndrome only.

6. Over-the-counter drugs are covered only when prescribed in large quantities for continuing use in treatment of specific conditions and with prior authorization.

7. Contraceptive drugs, supplies and birth control devices are covered and claimed at the increased Federal match under Family Planning.

8. No coverage is provided for items such as:
   - Dentifrices and dental adhesives
   - Baby oils
   - Soaps and shampoos - nonmedicated, (medicated products may be covered when prescribed by a physician)
   - Food products and food supplements; (payment may be made for food supplements (e.g., Sustacal) in cases where a person's nutritional needs can only be met by a liquid high protein diet.)
   - Baby formula; e.g., Enfamil, ProSobee, Similac (with or without iron), etc.
   - Sugar substitutes; e.g., Saccharin, Sweets, etc.
   - Antiseptics; e.g., Merthiolate, Tincture of Iodine, etc.

PRESCRIBED DRUGS (Continued)

Lotions and liniments; e.g., rubbing alcohol, witch hazel, Musterole, Vicks Vaporub, Ben Gay, etc.
Band-aids, gauze, adhesive tape, etc.
Ostomy Deodorants, oral or external Patent medicine; e.g., Carter's pills, etc. Tonics; e.g., Geritol, etc. Placebo; tablets, capsules, or solutions
Cough syrups; for which a prescription is not required by State or Federal law or regulation

Pharmacological intervention with nonamphetamine anorexiants for the short-term treatment of obesity may be covered if the drug has been approved by the Medical Director, Office of Vermont Health Access and prior authorization has been obtained.

*With the exception of prescriptions authorized for coverage via the procedure for requesting Medicaid coverage of a service or item (M108) found at Attachment 3.1-A Page 6o. This Procedure may be applied to all prescribed drugs.

ITEM 12. PRESCRIBED DRUGS, DENTURES, AND PROSTHETIC DEVICES, AND EYEGLASSES PRESCRIBED BY A PHYSICIAN SKILLED IN DISEASES OF THE EYE OR BY AN OPTOMETRIST

b. Dentures

Provided with no limitation, EPSDT only.

Provided with limitations, no partials or implants, for adults*.

c. Prosthetic Devices

Prosthetic devices are covered only by prior authorization except for breast prostheses, trusses, and prosthetic socks which require only a physician's order.

Hearing aids are not covered for recipients 21 or older and are only covered for recipients under age 21 when they are determined to be medically necessary pursuant to § 1905 (r) of the Social Security Act.

Augmentative communication devices are covered for all beneficiaries when medically necessary, with prior authorization*.

Wheelchairs are covered, with limitations*.

d. Eyeglasses

Eyeglasses are limited per beneficiary to*:

One pair of eyeglasses every two years.

Repairs and replacements when necessary.

Contact lenses by prior authorization except for patients with a diagnosis of aphakia.

Photosensitive materials incorporated in or applied to lenses with cataract surgery or when prior authorized.

Exceptions due to proven medical necessity.

Other aids to vision, such as closed circuit television, when the beneficiary is legally blind and when providing the aid to vision would foster independence by improving at least one activity of daily living (ADL or IADL).

*With the exception of services authorized for coverage via the procedure for requesting Medicaid coverage of a service or item (M108) found at Attachment 3.1-A Page 6o.

ITEM 13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in the plan.

Additional diagnostic, screening, preventive or rehabilitative services provided to EPSDT eligible recipients may require medical necessity review.

1. Diagnostic Services

Diagnostic services provided by state and/or local education agencies are covered when provided pursuant to the development of an Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP) for special education students as defined under Part B or Part H of the Individuals with Disabilities Education Act.